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We appreciate the opportunity to offer Kaiser Permanente's perspective on California's public health infrastructure, and its capacity to protect the public from natural and intentional threats to health. We have a keen interest in this Commission's deliberations, and have been privileged to participate in its work.

Kaiser Permanente is uniquely qualified to comment on this topic. Our role in health care and our social mission make it imperative that we engage in and actively support public health initiatives. We have long worked with public health officials on disease surveillance and immunization initiatives, for example. Our model of care emphasizes prevention. We want our members to live in safe and healthy communities, and our Community Benefit program invests considerable resources directly in community health programs. We have already been on the front lines of a bioterrorism attack – anthrax in the nation's capital. And as a large complex organization, we have had to take diligent steps to assure that we can inform our members and staff, and continue to deliver health care, in the event of a major natural or manmade disaster. For all these reasons, we are in a position to identify ways to strengthen the public health infrastructure, and to offer our continuing collaboration in meeting the challenges we all face together.

I will comment first on an issue of immediate interest to this Commission – bioterrorism and the capacity of California's public health system to respond to emergencies and to protect the public from imminent health threats. I will then address more broadly the needs of public health and the conditions for success. There are four central points I want to make: (1) that communication, and clear lines of authority and responsibility, are essential to public health preparedness and incident response; (2) that investment in the core public health capacity of disease surveillance is a critical need; (3) that an informed and mobilized community is central

to success; and (4) that public health, especially in today's world, must engage not just governmental agencies but partnerships with the nonprofit and the private sectors, and with our communities as well.

First, let me set the context.

As the world's largest non-governmental health care system, with nearly 8.4 million members, Kaiser Permanente has always participated actively in public health and disaster preparedness efforts. The scope of our responsibility is huge: in the San Francisco Bay Area, for example, nearly one out of every three persons is a Kaiser Permanente member, as are more than 6.3 million Californians (18% of the population of the entire state). Our diverse population, range of in-house services, broad experience in medical training and research, contacts with medical suppliers, and expertise in health care continuity planning provide us with the foundation to partner with government agencies and other health care organizations.

Following the September 11 tragedies and the subsequent anthrax attacks, we expanded our disaster planning capabilities to include terrorism preparedness. We faced several real-life situations that tested our ability to respond quickly and effectively to incidents of bioterrorism and to repercussions from the September 11 tragedies. As a result, we identified "barriers to success" that require government, industry and community cooperation to ensure that critical health care functions will continue during major emergencies. We are sharing these findings with key state officials and have been working closely with Dr. Bonta and Dr. Burton in developing further plans.

The following table highlights the barriers we identified, as well as our recommendations for improvement. These findings and recommendations cover the national, state and local levels of public health, and involve not only government entities but the private sector as well.

Terrorism/Disaster Preparedness
Barriers and Recommendations

Barriers	Recommendations
Lack of coordinated advance planning before an event occurs.	• Appropriate governmental and public health agencies should establish processes with hospitals and health care providers for planning, consultation, and coordination on appropriate stockpiles and sources of supplies, vaccines, and antibiotics. • Hospitals and health care providers should share best practices in emergency preparedness. • Integrate terrorism preparedness, including bioterrorism preparedness, into ongoing community emergency/disaster planning. • Government and the health care industry should determine the level of resources necessary to conduct reliable threat assessment evaluations.
Lack of mechanisms for incident reporting and communication.	• Designate and widely communicate one governmental single point of contact for incident reporting. • Provide resources for public health agencies to develop effective community-wide syndromic surveillance systems.
No clear process for information dissemination.	• Federal, state, and local agencies should develop a streamlined process to convey information about potential/current threats and emergency events, both within layers of government, and to the health care industry and other first responders. • Intelligence agencies, public health agencies, and the health care industry should develop linkages, so that health care first responders can successfully prepare for potential threats, and respond effectively if they do occur.
Confusion over jurisdictional, regulatory, and governmental responsibilities.	• Starting with the Office of Homeland Security, governmental and regulatory agencies should establish and communicate clear lines of authority for all events, from criminal activities to public health incidents. • Governmental and public health agencies should establish a single point of contact for hospital/health care responders, both for policy and preparedness issues, and for emergency events. • Public and private entities should work together to improve policy and emergency coordination among federal/state, state/local, local/health care providers and hospitals. Examples include defining lead agencies for each potential disaster, establishing a chain of custody for evidence collection, and providing guidelines for federal assistance.
Obstacles to filling human resources needs.	• States should adopt an emergency procedure for licensing out-of-state health care workers during disaster/terrorist situations requiring a significant medical response.

Barriers	Recommendations
Lack of clinical protocols and medical information.	• The U.S. Centers for Disease Control and Prevention (CDC), working collaboratively with health care organizations and experts, should develop clinical protocols for multiple potential disaster scenarios, including bioterrorism, chemical, nuclear, and radiologic incidents. These recommendations must be widely disseminated and widely accepted by medical experts. • The federal government and the pharmaceutical industry should make it a high priority to encourage the development of effective vaccines and pharmaceuticals to protect the public against bioterrorism and other terrorist incidents.
Lack of coordinated training programs.	• Government agencies and the health care industry should jointly develop core elements of training for various responders and the general population.

For each identified barrier to success, Kaiser Permanente identified ways in which we are prepared to provide special assistance. Some examples include:

- In a joint effort with the California Department of Health Services and the American Public Health Association, we sponsored a September conference in Los Angeles to increase the awareness of the public, health professionals, and business leaders about bioterrorism.
- We are sharing our clinical protocols with the U.S. Centers for Disease Control and Prevention (CDC).
- We made a $1 million three-year grant to RAND to support development of its Center for Domestic and International Health Security.
- Our Kaiser Permanente Vaccine Study Center is participating in two major studies that will test the effectiveness of different versions of the smallpox vaccine.
- We are pilot testing a syndromic surveillance system in one California county, working with the local public health department and local hospitals; we are participating in design and testing of another approach to syndromic surveillance in our Colorado Region.
- We continue to work with elected officials on legislative proposals to improve emergency preparedness.

Building on the health care continuity management model we already had in place, Kaiser Permanente launched a rigorous threat assessment process to plan for major medical

emergencies. Work groups organized around specific disciplines, including clinical, facilities, people, supply chain, public policy, community linkages, and communications/education began developing new protocols to ensure an integrated threat reduction and management program. Our approach to terrorism preparedness may offer a model for others to consider. We also welcome feedback and suggestions for improvement.

Let me turn now turn to broader issues concerning public health capacity. As numerous experts have testified previously, the basic infrastructure of public health in this country – the people, expertise, equipment and resources – has been allowed to deteriorate for many years. California has maintained and supported that infrastructure more successfully than most states, but it has not been immune to the forces undermining public health. Public health spending has not kept pace with the demands on public health systems, but other factors have been important as well: the changing nature of biological threats (not just bioterrorism, but emerging and re-emerging infections), the rapid pace of technological development, changes in the health care market and delivery system, and lack of general public understanding of public health.

These forces have particularly affected the backbone of public health: infectious disease surveillance. Disease surveillance is the capacity to detect outbreaks; to detect change in the epidemiology of infection; to inform and motivate a public health response at both the population and individual level; to assess the health status of the public; to evaluate prevention and control interventions; to aid in understanding the etiology and natural history of disease; to assist in health planning; and to identify research needs.

A study I directed three years ago for the Assistant Secretary of HHS in Washington identified four major gaps in surveillance capacity. First, the core capacity of local and state public health entities has not been uniformly adequate to protect the public: performance standards and capacity requirements are not clear; staff capacity is often insufficient to support ongoing evaluation and analysis; and computerized decision and analytic support tools are not well developed or utilized. Second, the non-governmental sectors have not been well engaged: physician and lab reporting are incomplete and not timely; there is little feedback to support voluntary participation; professional training offers little exposure to public health methods; and communication with key constituencies, such as policymakers and media, is weak. Third,

private lab support has been eroding as new technology focused on clinical rather than public health applications, putting greater burden on already stressed public health laboratories. Fourth, advances in information technology have not been widely or uniformly adopted in public health application. And finally, categorical government funding has remained a major barrier to development of an integrated and effective surveillance infrastructure.

We estimated at that time that multi-year investment of at least $5 billion was needed to bring the nation's surveillance system back to functional capacity in staffing, technology and communication capability. The bottom line is that we cannot build a robust all-hazard preparedness and response system on a weak basic public health infrastructure.

I also want to speak to the issue of public information and mobilization. Two recent foundation-sponsored initiatives – the national Turning Point collaboration of the W. K. Kellogg and Robert Wood Johnson Foundations, and the Partnership for the Public Health initiative of The California Endowment with the Public Health Institute – are teaching us much about a different way of thinking about public health infrastructure. Unlike programs that would increase federal capacity and flow funds down through state health departments and regional consortia, these programs start at the local level, building broad community support and participation in public health priority setting and action. And unlike programs that begin by training more professionals, improving technology, and linking local, state, and federal agencies more closely, these partnership programs begin with what some would call "social capital," engaging and linking affected people at the local level. These two approaches neither antagonize nor compete with one another. The most mobilized community cannot succeed without the necessary professional and technical resources at its command, nor can technical capability work in isolation from engaged and informed communities that are active participants.

The essence of what we are learning from these initiatives is that linkages, created by broad-based community partnerships deeply involved in the work of public health, significantly extend and enhance what is usually known as "public health infrastructure," namely the skills, resources, and influence associated with official local and state public health agencies and the professionals who work with them. This "integrating capacity" maximizes the value from

"functional capacities" like equipment, trained personnel, advanced information technology, and current funding.

An emerging public health policy suggested by these foundation initiatives would support partnerships that would broaden public health funding beyond the sole jurisdiction of government health agencies, and acknowledge that communities might take different organizational approaches to meeting their need. It would make direct investments in local capacity building, grounded in local assessment of needs and identification of priorities. It would encourage government-industry-community partnerships to increase needed personnel and technological capacity in local health departments. And it would mount education programs to familiarize healthcare workers and the public at large with public health methods, and to increase public health's capabilities in communication and facilitation with non-governmental and non-health interests.

Finally I want to emphasize a point that may be obvious to some -- insuring the health of the public in today's world requires the engagement and involvement of many elements of the nonprofit and private sectors, as well as the general public and our communities. It is of course essential to improve the capabilities and capacity of our federal, state and local government public health agencies. However, by themselves, they will not be sufficient nor successful. Protecting and improving the public's health will require a combined and coordinated effort by all of us.

We appreciate the opportunity to contribute these observations and suggestions to the deliberations of this Commission. To reiterate: (1) communication, and clear lines of authority and responsibility, are essential to public health preparedness and incident response; (2) investment in the core public health capacity of disease surveillance is a critical need; (3) an informed and mobilized community is central to success; and (4) successful public health requires government's active partnership with the nonprofit and private sectors and with the public as a whole. We stand ready to play an active part in the evolving policy and practice around strengthening public health capacity in California.